

STATE OF MONTANA

**DEPARTMENT OF LABOR & INDUSTRY
BUSINESS STANDARDS DIVISION**

LICENSED ADDICTION COUNSELORS PROGRAM

APPLICATION Procedure & Application FORM

July 1, 2005

LICENSED ADDICTION COUNSELORS PROGRAM

**301 South Park Avenue
PO Box 200513
Helena, MT 59620-0513
Phone: (406) 841-2392, Fax: (406) 841-2305
E-mail – dlibsdlac@mt.gov
<http://www.lac.mt.gov>**

Montana Licensed Addiction Counselors Program
301 South Park Avenue 4th Floor
PO Box 200513
Helena MT 59620-0513
PHONE: 406-841-2392 FAX: 406-841-2305 or 439-4567
E-MAIL: dlibsdlac@mt.gov
WEBSITE: <http://www.lac.mt.gov/>

APPLICATION PROCEDURES FOR LICENSED ADDICTION COUNSELING

PLEASE ALLOW 30 DAYS FOR PROCESSING AFTER RECEIPT OF ALL REQUIRED DOCUMENTATION

LICENSURE REQUIREMENTS:

- ☐ Must provide an official transcript from an accredited college or university,
- ☐ Must provide verification of 270 contact hours of specific chemical dependency/addiction and counseling courses or accumulated hours,
- ☐ Must have completed 1000 hours of supervised work experience,
- ☐ Must have passed the Montana Written.

FEES FOR LICENSURE:

- ☐ \$200.00 Application Fee.
- ☐ \$100.00 Written Exam Fee, upon completion of supervision,

Make check or money order payable to the Montana Licensed Addiction Counselors Program.

DO NOT SEND CASH

APPLICATION PROCEDURES AND SUPPORTING DOCUMENTS:

The following information and/or documentation are required.

An application will not be accepted nor a license issued until all materials are received and approved.

1. Completed application form and application fee,
2. An official transcript from an accredited college or university,
3. Verification of 270 specific contact hours,
4. Identification of supervision site or verification of 1000 hours of supervised work experience.

MONTANA LICENSED ADDICTION COUNSELORS PROGRAM

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Helena, Montana 59620-0513
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E-mail: dlibsdlac@mt.gov
<http://www.lac.mt.gov/>

Application for Licensure:

- ☐ Exam
☐ Endorsement

PLEASE PRINT IN INK OR TYPE

1. FULL NAME: _____
Last First Middle
2. OTHER NAME (S) KNOWN BY: _____
3. BUSINESS NAME: _____
4. BUSINESS ADDRESS: _____
Street or PO Box # City and State Zip Country
5. HOME ADDRESS: _____
Street or PO Box # City and State Zip Country
- PREFERRED MAILING ADDRESS: ☐ Business ☐ Home E-MAIL ADDRESS: _____
6. TELEPHONE: (_____) _____ (_____) _____ (_____) _____
Business Home Fax
7. SOCIAL SECURITY NUMBER: _____ FOREIGN ID NUMBER: _____
8. DATE OF BIRTH: _____ PLACE OF BIRTH _____
City/State ☐ MALE ☐ FEMALE
9. CERTIFICATE NAME: _____
(State your name, as it should appear on the certificate/license if granted.)

Please answer the following questions.

If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplement Sheet.

10. If taking an examination, do you have any physical or mental impairment(s) requiring special accomodation(s)? If yes, please attach a detailed explanation. ☐ Yes ☐ No
11. Have you ever taken the certification/licensure examination in Montana or any other state? If yes, give state, date, and results. ☐ Yes ☐ No
12. Have you ever been denied the right to take this profession's licensing examination in any state? if yes, attach a detailed explanation. ☐ Yes ☐ No
13. Have you ever previously applied for a certificate to practice in Montana? If yes, give date and results. ☐ Yes ☐ No
14. Have you ever withdrawn an application for addiction licensure or certification? ☐ Yes ☐ No

15. COMPLETE 15a AND 15b IF YOU ARE APPLYING FOR ENDORSEMENT LICENSURE.

Questions 15a and 15b do not apply for applicants applying for licensure by exam.

a. List all chemical dependency/addiction licenses or certifications that you **currently** or have **ever** held. Verification must be sent directly to Montana from each state board.

State/Province/Territory	License/Certificate #	Date Issued	Current	Exam Taken – Oral - Written

b. PRACTICE HISTORY:

List **all** activities after education (other than those already set forth above) in chronological order, up to and including the present. Specify nature of activity; for example, private practice, state or county agency, hospital practice, school, private employment, etc. **Account for all periods of time longer than 1 month. Indicate specific month and year for each activity.** Use additional paper if necessary.

Activity _____ Inclusive Dates _____

Place (name & address) _____

Reason for leaving _____

Activity _____ Inclusive Dates _____

Place (name & address) _____

Reason for leaving _____

Activity _____ Inclusive Dates _____

Place (name & address) _____

Reason for leaving _____

16. Has a licensing agency ever taken adverse or disciplinary action against your chemical dependency license/certificate or application? If yes, attach a detailed explanation, identifying the conduct for which discipline was imposed, and the nature of the discipline (suspension, probation, etc.)

☐ Yes ☐ No

17. Have you ever voluntarily surrendered, cancelled or failed to renew a chemical dependency license/certificate during a disciplinary investigation of your chemical dependency practice, or entered into a consent agreement respecting your license/certificate during a disciplinary investigation? If yes, attach a detailed explanation identifying each occasion, the date, and the substance of the allegations.

☐ Yes ☐ No

18. Have you ever voluntarily or involuntarily surrendered any privileges, health maintenance organization participation, Medicare/Medicaid privileges or other counseling staff privileges during a pending investigation, or in anticipation of an investigation or had such privileges denied, restricted, suspended, placed on probation, revoked or subjected to other disciplinary action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations.

☐ Yes ☐ No

19. Has a complaint ever been made against you alleging unethical behavior or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No
20. Has any legal or disciplinary action been filed against you which relates to the propriety of, or your fitness to practice this profession? If yes, attach a detailed explanation of each instance including the date of claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No
21. Have you ever voluntarily or involuntarily surrendered privileges to practice, or had privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any government agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary board, court, or other entity? If yes, attached a detailed explanation. ☐ Yes ☐ No
22. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No
23. Do you have criminal charges pending or have you ever plead guilty or been convicted of a crime (including a plea of no contest or deferred prosecution) relating to, or committed during your professional career, or a crime, involving violence, use or sale of alcohol or drugs, fraud, deceit, or theft, whether or not an appeal is pending? You may omit: traffic violations for which you paid a fine of \$100.00 or less and (2) charges or convictions prior to your 16th birthday. If yes, attach a detailed explanation. ☐ Yes ☐ No
24. Have you ever been charged with fraud, formally or informally, in any civil proceeding? If yes, attach a detailed explanation. ☐ Yes ☐ No
25. Have you any physical or mental condition which has in the past three years adversely affected your ability to practice this profession, including but not limited to, a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No
26. Have you, within the last three years, used alcohol or any other mood-altering substance in a manner which adversely Affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No
27. I have read the entire Canon of Professional Ethical Standards for Chemical Dependency Counselors. ☐ Yes ☐ No
28. I agree to conduct myself in all my professional relationships in accord with Montana Codes Annotated, 37-305-301 and 7-1-316, and Administrative Rules of Montana 8.11.120. ☐ Yes ☐ No
29. I am aware that a violation of any one of the standards constitutes a breach of ethical conduct and could result in the suspension or revocation of my certificate, pursuant to Montana Codes Annotated, 37-305-301 and 7-1-316, and Administrative Rules of Montana 8.11.120. ☐ Yes ☐ No

Signature

Date

In addition to the above, required signature, all applicants must complete the affidavit on Page 7.

17. EDUCATION: ALL APPLICANTS MUST COMPLETE AND HAVE PROCESSED FORM A.

a. University or College Education

Name & Address of institution: _____

Dates attended: _____ Degree Earned & Date: _____

b. Chemical Dependency Addiction Education.

Name & Address of Institution: _____

Dates attended: _____ Degree Earned & Date: _____

Name & Address of Institution: _____

Dates attended: _____ Degree Earned & Date: _____

ALL APPLICATIONS MUST INCLUDE VERIFICATION OF 270 HOURS OF COURSE WORK OR TRAINING SPECIFIC TO CHEMICAL DEPENDENCY/ADDICTION AND COUNSELING. OF THESE HOURS 150 HOURS MUST BE ACQUIRED IN THE FOLLOWING AREAS WITH ALL ADDITIONAL HOURS LISTED BELOW. Use additional paper if necessary. PLEASE INCLUDE AN OFFICIAL TRANSCRIPT AND COPIES OF CERTIFICATES OF COMPLETION FOR ANY AND ALL ADDITIONAL HOURS.

NAME OF TRAINING	DATES	HOURS AWARDED
30 hours -Addiction Assessment:	_____	_____
45 hours -Addiction Counseling:	_____	_____
12 hours -Pharmacology:	_____	_____
6 hours -Ethics for Addiction Counselors:	_____	_____
30 hours -Alcohol and Drug Studies:	_____	_____
15 hours -Addiction Treatment Planning & Documentation:	_____	_____
12 hours -Multi-Cultural Competency:	_____	_____

ADDITIONAL TRAINING HOURS

NAME OF TRAINING	DATES	HOURS AWARDED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOTAL HOURS: _____

EDUCATION CATEGORY AS A RESULT OF HB 203	HOURS REQUIRED 1 SEMESTER CREDIT = 15 HOURS	CREDITS EARNED 1 SEMESTER CREDIT = 15 HOURS	COMMENTS
HUMAN BEHAVIOR, SOCIOLOGY, PSYCHOLOGY, OR A SIMLAR EMPHASIS	6 CREDIT HOURS - 90 CLOCK HOURS <input type="checkbox"/>		
PSYCHOPATHOLOGY OR COURSE WORK EXPLORING PATTERNS AND COURSES OF ABNORMAL OR DEVIANT BEHAVIOR	3 CREDIT HOURS - 45 CLOCK HOURS <input type="checkbox"/>		
COUNSELING	9 CREDIT HOURS GROUP COUNSELING 6 CREDIT HOURS 90 CLOCK HOURS THEORY OF COUNSELING 3 CREDIT HOURS 45 CLOCK HOURS <input type="checkbox"/>		

18. **SUPERVISION:**

-LICENSURE APPLICANTS NOT YET ENGAGED IN OR HAVING COMPLETED SUPERVISION, PLEASE COMPLETE FORMS D, E, AND F.

-ALL LICENSURE APPLICANT SUPERVISORS MUST BE APPROVED BY THE DEPARTMENT AND HAVE SUBMITTED FORM G.

a. Supervised Work Experience:

Program & Address

Dates attended: _____

Telephone Number: (_____) _____

Supervisors Name (Please print): _____ Title _____

b. Supervised Work Experience:

Program & Address

Dates attended: _____

Telephone Number: (_____) _____

Supervisors Name (Please print): _____ Title _____

c. Have you ever been certified by a Specialty Board?

☐ Yes ☐ No

Specialty _____ Date Awarded, Recertified _____

Name & Address of certifying agency _____

d. Have you ever been denied specialty certification/licensure or failed to pass a specialty licensure examination or portion thereof? ☐ Yes ☐ No

By whom? _____

Reason for denial? _____ Number of times failed _____

19. **PROFESSIONAL & CHARACTER REFERENCES.**

Please type or print names and addresses of three references, who have known or associated with you for at least one year.

Name:
Address:
Telephone Number:
Name:
Address:
Telephone Number:
Name:
Address:
Telephone Number:

FORM A

PLEASE GIVE THE NAME, ADDRESS AND PHONE NUMBER OF THE REGIONAL ACCREDITING ASSOCIATION AND THE DATE THAT YOUR SCHOOL WAS REGIONALLY ACCREDITED.

Association: _____

Address _____

City, State, Zip _____ Date Accredited: _____

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana LICENSED ADDICTION COUNSELORS PROGRAM.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and am familiar with the applicable licensure laws of the State of Montana and instructions to applicants for licensing. I accept the rules and procedures outlined in these documents as the basis for my application.

Legal Signature of Applicant

Dated

Subscribed and sworn to by me this _____ day of _____,
_____ at _____

City/State

Notary Public

SEAL

For the State of

My commission expires: _____, _____.

VERIFICATION OF CHEMICAL DEPENDENCY ADDICTION EDUCATION

The applicant must forward this form to their school for verification of applicants' degree. The school must complete this form and return it with **AN OFFICIAL TRANSCRIPT TO:**

**DEPARTMENT OF LABOR & INDUSTRY
LICENSED ADDICTION COUNSELORS PROGRAM
PO BOX 200513
HELENA, MT 59620-0513**

ACADEMIC VERIFICATION

It is hereby certified that _____ of _____

Graduated from _____ Location _____

Date Graduated _____, and is to the best of our knowledge is of good moral character.

(SEAL OF SCHOOL)

President, Dean or Registrar Signature _____

Date Certified _____

FORM B

BACKGROUND CHECKS

BACKGROUND CHECKS WILL BE CONDUCTED ON ALL APPLICANTS FOR LICENSURE.

Date of Birth: _____ **Sex:** _____ **Social Security Number:** _____

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE ENCLOSE EXPLANATION ON A SEPARATE SHEET.

Have you ever been convicted of a felony (including conviction with deferred sentence)?

☐ **YES** ☐ **NO**

If "YES" List State(s): _____

Date(s) of Conviction(s): _____

Have you ever had any professional certification or license suspended, revoked, or had any other disciplinary action taken in any state?

☐ **YES** ☐ **NO**

Do you have any pending complaints from a licensure board or professional counseling organization?

☐ **YES** ☐ **NO**

Signature

Date

Date: _____

FORM D

VERIFICATION OF SUPERVISION HOURS

To be completed by applicants who have not completed supervision work experience.

WORK EXPERIENCE: Supervised Addiction/Chemical Dependency work experience to be completed at:

Name of Montana Treatment Setting	Address	City/Zip
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(_____) _____ Telephone Number	_____ E-mail address
-----------------------------------	-------------------------

Beginning Date	Projected Completion Date
----------------	---------------------------

SUPERVISOR'S NAME (Please Print)	Title
----------------------------------	-------

LICENSE NUMBER	E-MAIL ADDRESS
----------------	----------------

SUPERVISOR'S SIGNATURE	Date
------------------------	------

This supervised work experience will be:

☐ Paid Position ☐ Volunteer Position ☐ Internship ☐ Full Time ☐ Part Time

FORM E **WEEKLY TIME SHEET**

Eligible Counselor: _____

WEEK OF: _____

Skill Groups	SUN	MON	TUES	WED	THUR	FRI	SAT	Total This Week	Total Prior to this Week	TOTAL TO DATE
*CLINICAL EVALUATION										
SCREENING										
ASSESSMENT										
*TREATMENT PLANNING										
*REFERRAL										
*SERVICE COORDINATION & CASE MANAGEMENT										
*INDIVIDUAL COUNSELING										
*GROUP COUNSELING *SERVICES FOR FAMILIES, COUPLES & INTIMATE DYADS										
*CULTURAL COUNSELING										
*CLIENT, FAMILY, & COMMUNITY EDUCATION										
*DOCUMENTATION *PROFESSIONAL AND ETHICAL RESPONSIBILITIES										
TOTALS										

The eligible counselor must maintain and sign the **Weekly Time Sheet**. The Supervisor will sign to verify hours recorded by the eligible counselor.

Summary Sheets of the **Supervised Counseling Experience** will be attached to Weekly Time Sheets and submitted to the Licensure Program at the completion of the 1,000 Hours required before examination.

Summary Sheets must be signed by the Eligible Counselor and the Licensed Counselor responsible for the supervision.

Eligible Counselors gaining the required work experience in **more than one setting and/or supervised by more than one licensed counselor** will complete and sign a **Summary Sheet** of hours for each supervisor until the required 1,000 hours are completed.

Eligible counselors must receive 500 of the 1,000 hours experience in the following areas:

Screening –	30 hours	Case Management–	50 hours	Client Education –	40 hours
Assessment/Patient Placement –	100 hours	Individual Counseling –	60 hours	Documentation –	40 hours
Treatment Planning –	50 hours	Group Counseling –	100 hours	Professional &	
Referral –	20 hours	Multi-Cultural Competency –	12 hours	Ethical Resp. –	10 hours

***80 Hours of Direct Supervision required for 1,000 hours of supervised counseling experience.**

APPLICANT'S SIGNATURE: _____ DATE: _____

SUPERVISOR'S SIGNATURE: _____ DATE: _____

FORM F
DEPARTMENT OF LABOR AND INDUSTRY
HEALTH CARE DIVISION
LICENSED ADDICTION COUNSELORS PROGRAM
Supervised Counseling Experience
SUMMARY SHEET

Eligible Counselor	Treatment Setting
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Name of Supervisor	Date Began	Date Completed
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One complete Summary Sheet must be attached to **Weekly Time Sheets** submitted to the LICENSED ADDICTION COUNSELORS PROGRAM to document supervised counseling experience of eligible counselors.

Individuals completing the required work experience on a **full time basis** in **one treatment setting** will submit 26 weekly time sheets and one Summary Sheet.

Individuals completing the required work experience in **more than one treatment setting** are required to submit a Summary Sheet for each setting signed by the supervisor responsible for supervision of the work.

Eligible counselors are permitted to complete work in no more than two treatment settings. (Internship hours earned through an academic chemical dependency field placement is not included in the limit of two treatment settings.)

<u>Counselor Skill Groups</u>	<u>Minimum Hours Required</u>	<u>Hours of Direct Supervision</u>	<u>Total Hours Accumulated</u>
CLINICAL EVALUATION			
Screening	30 Hours	_____	_____
Assessment/Patient Placement	100 Hours	_____	_____
Treatment Planning	50 Hours	_____	_____
Referral	20 Hours	_____	_____
Case Management	50 Hours	_____	_____
Individual Counseling	60 Hours	_____	_____
Group Counseling	100 Hours	_____	_____
Multi-Cultural Competencies	12 Hours	_____	_____
Client Education	40 Hours	_____	_____
Documentation	40 Hours	_____	_____
Professional/Ethical Concerns	10 Hours	_____	_____

TOTAL HOURS OF DIRECT SUPERVISION*

TOTAL HOURS SUPERVISED EXPERIENCE

**80 Hours of Direct Supervision required for 1,000 hours of supervised counseling experience.*

***Total of 1,000 Hours Supervised Counseling Experience Required for Licensure*

Counselor's Signature	Date	Supervisor's Signature	Date
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FORM G
DEPARTMENT OF LABOR & INDUSTRY
LICENSED ADDICTION COUNSELOR PROGRAM

APPLICATION TO SUPERVISE COUNSELING EXPERIENCE

Montana Licensed Addiction Counselors may apply for approval to supervise the work experience of applicants for licensure. Licensed counselors must have a minimum of three- (3) year's chemical dependency counseling experience in an approved treatment setting (see the Licensure Manual). Approval to supervise counseling experience is only submitted one time and will remain in effect as long as the counselor is licensed.

First Name

Middle

Last Name

Street Address

Mailing Address if different

City

State

Zip

(_____) _____

Home Telephone Number

(_____) _____

Work Telephone Number

E-mail address

License #

EFFECTIVE DATE

Expiration Date

Three years CD counseling experience (post Certification/ Licensure) completed in a Chemical Dependency Treatment Setting:

Program Name

Street Address

City

State

Zip

(_____) _____

Telephone Number

E-mail address

Date of Employment

From

To

Supervisor

A signed copy of this approval will be returned to the licensed counselor making application.

APPROVED: _____
Signature – Licensure Program Manager

DATE APPROVED: _____

All applications must include the application fee of \$200.00. MAKE CHECKS OR MONEY ORDER PAYABLE TO:

**DEPARTMENT OF LABOR & INDUSTRY
LICENSED ADDICTION COUNSELORS PROGRAM
301 SOUTH PARK AVE., P.O. BOX 200513
HELENA, MT. 59620**

Applicants applying for licensure can expect to receive a response regarding their application within 30 days of its receipt at the Chemical Dependency Licensure office.

Applicants who have successfully completed the licensure process can expect to receive their License within 10 working days.

STUDY GUIDE AVAILABILITY

The Association for Addiction Professionals (NAADAC) makes available a Desk reference and Study Guide on Addiction Counseling. The cost of the Guide is \$100 plus \$5 s/h. You may place your order by calling 1-800-548-0497, fax at 703-741-7698, or e-mail at www.naadac.org or by mail at:

*NAADAC.
The Association for Addiction Professionals
901 N. Washington St. Suite 600
Alexandria, VA 22314*

REDUCED RATE AVAILABLE.

The cost of the guide is reduced to \$70 plus s/h if applicants becoming a NAADAC/NAADAC member. An application brochure is included within the mailed licensure packet or by contacting the licensure office at 841-2392.

I WOULD LIKE MY NAME INCLUDED ON A MAILING LIST OFFERING CONTINUING EDUCATION, TRAINING, AND EMPLOYMENT OPPORTUNITIES.

☐ YES

☐ NO

Essential Resources for Alcohol and Drug Professionals from NAADAC



ORDER >>

NAADAC Best-Seller

Basics Of Addiction Counseling: Desk Reference And Study Guide

This recently updated manual is designed as an outline of the knowledge base for the alcoholism and drug abuse counseling profession. The manual is an invaluable reference tool for experienced professionals and is also useful as an aid in preparation for certification exams. Divided into four modules, it encompasses the pharmacology of psychoactive substances, counseling skills and practice, the theoretical base of counseling, and professional issues. A bibliography is included for further study. Contributors include: Janice Gabe, MSW, MAC, Merrill Norton, RPh, NCAC II, CCS, Michael Taleff, PhD, CAC, MAC, and Kathryn Benson, NCAC II.

Regular Price: \$100
 Member Discount Price: \$60
 Organizational Member Discount Price: \$80

EDUCATION CATEGORY AS A RESULT OF HB 203	HOURS REQUIRED 1 SEMESTER CREDIT = 15 HOURS	CREDITS EARNED 1 SEMESTER CREDIT = 15 HOURS	COMMENTS